

COMPREHENSIVE CARE CLINIC PATIENT CARD

Unique patient Number _____ MOH 257

DEMOGRAPHIC CHARACTERISTICS:Patients Name _____ Unique Pt No.

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Year of Birth _____ Age _____ Sex: ☐ Male ☐ Female

Postal Address _____ Tel Contact: _____

District: _____ Location _____

Sub-location _____ Nearest school _____

Nearest church _____

Marital Status :☐ Married Monogamous ☐ Divorced ☐ Single☐ Widowed ☐ Married polygamous ☐ Cohabiting

Name of treatment Supporter _____ Relationship to Patient _____

Postal Address _____ Tel No _____

Entry point:☐ PM= PMCT ☐ VCT= Voluntary Counseling and Testing☐ TB= TB patient ☐ I = Inpatient ☐ MCH=Mother Child Health clinic☐ Others (specify e.gSTI, CBO etc).....**ART History**☐ Transfer in with records ☐ Earlier ARV but not a transfer in☐ PMCT only ☐ None

Date patient HIV test confirmed +ve _____ where? _____

Date enrolled in HIV care clinic

Date PEP offered _____ Reason for PEP _____

KNOWN DRUG ALLERGIES _____

ART THERAPY:

Date medically eligible _____ WHO clinical stage _____

Reason for eligibility ☐ CD4/% ☐ Clinical only ☐ TLC

Date eligible and ready for ART _____

Transfer in with Records? Date _____

From: Name of District _____

Name of facility _____ Date started ART _____

COHORT: Month _____ Year _____

Date started on 1st line initial regimen _____ Regimen _____

At start of ART: Weight(Kgs) _____ Function status _____ WHO Clinical stage _____

Substitution of ARVs within first line regimen

Date _____ New Regimen _____ Reason for substitute _____

Date Switched to 2nd line regimen _____ Regimen _____ Reason _____

Substitution of ARVs within 2nd line regimen:

Date _____ New Regimen _____ Reason for substitute _____

Date patient transferred out _____ To where _____

ART treatment interruptions

Stop/Lost/Dead (Circle appropriately)	Date	Reason/s for STOP	Date Restarted
Stop/Lost/			
Stop/Lost/			
Stop/Lost/			
Stop/Lost/			
Stop/Lost/			
Dead			

HIV CARE/ART PATIENT CARD

Unique Patient ID_____

MOH 257

Date (Tick if visit is scheduled/If patient is ill write pick -up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follow up date										
Duration in month since start of ART										
Weight (Kgs)										
If Pregnant. EDD.PMCT? FP or NO FP If FP . Method? IF CHILD- HEIGHT Function: W, A, B										
WHO clinical stage										
TB Status										
Potential Side effects										
New OI, Other Problems										
Cotrimoxazole Adherence Dose										
Other medications dispensed										
Adherence? WHY?										
ARV drugs Regimen/Dose dispensed										
CD4/% / Results/ Date										
HB,TLC,HEP 'B',other lab tests										
Referred To?										
If hospitalized, No. of days										
Clinicians initials										

Yellow highlights show the variables abstracted from the patient data.